**Interview with Dr. James O. Finnegan, surgeon formerly of Delta Med and Charlie Med (Khe Sanh), 3rd Medical Battalion in Vietnam, 1967- 1968. Conducted by Jan K. Herman, Historian of the Navy Medical Department, Kansas City, MO, 9 September 2004.**

**Where are you from?**

I was born and raised in Pittsburgh, PA. I went to grade school and high school there and started college at the University of Pittsburgh on what was then called the "Honor Scholarship." The social life, however, overwhelmed me a bit and after 2 years I found myself sans scholarship and not exactly on the dean's list. I was taught in High School by a religious order called the Christian Brothers. In the fall of my third year at Pitt, I went back to my high school principal whose name was Brother Giles Vincent and I said, "Brother Vincent, I'm not doing well.

He picked called LaSalle University in Philadelphia and arranged for me to transfer there in January. I'd never been east of Pittsburgh in my life. In a year and a half at LaSalle, I managed to accumulate enough premed credits with good grades to get into med school at Hahnemann Medical College in Philadelphia. I spent 4 years there in school and a year there at Hahnemann Hospital for my internship. Once again, serendipitously, one of the professors of surgery there, who I had worked with as a student, briefly said to me that he thought I should go into surgery. I had been in the OR with him a little bit and said that I wasn't sure about that. At the time, I really wanted to be an internist. He said that he was convinced that I should be a surgeon. To encourage me, he said, "If you're interested, I'll sponsor you at the University of Pennsylvania."

It sounds easy today but back then I was extremely frightened. Penn was The Mecca. Average, little, shanty Irish kids from Pittsburgh did not go to Penn to train in surgery. Somehow I said I'd try it, I interviewed, and got accepted.

I still remember going over in my little white outfit and thinking that all these guys are going to show up from Harvard and Yale and I'm going to look like a total ditz. But it turned out that they all put their pants on one leg at a time. Some of them couldn't cut their way out of a paper bag. It worked out okay.

In the midst of it, in my second year of my surgical training, a fellow named Jonathan E. Rhoads became the John Ray Barton Professor and Chairman of the department. Unbeknownst to me, he was a lifelong, strong Quaker. It was nothing he ever talked about or you would ever know, except through the grapevine. As I finished my second year of training, Vietnam was heating up more and more. My father came from a long line of warriors but was kept out of World War II because he was a steelworker. He spent his life regretting it. He actually tried all kinds of subterfuges to get in the service but they blocked him at every point and sent him back to the mill to make guns or howitzers, or some damn thing. When the war ended, he was 27 or 28. All through my childhood he would say, "You're going to serve in the military, no matter what else you do."

So, that's how I had that fixed in me that I would do that. When I saw the Vietnam thing building up I thought that if I waited to the end of my training, this thing could be over and I'd miss it. It sounds horribly naive in retrospect but that's exactly what it was. I wanted to go to war, perhaps subconsciously to please my father.

I was on the Berry Plan with the Navy. I started writing to the head of the Navy manpower bureau in Washington. I can't remember his name right now. I wrote: "If I relinquish my deferment, will you guarantee me a position as a surgeon in Vietnam?"

And I got all these fuzzy letters back: "The needs of the service . . . ," the usual. My reaction was, "No dice, pal. I'm not going to make this move and leave my residency and go to Vietnam to find out I'm doing sick call. You have to promise me that I will have a surgical billet or **no** dice."

I had no way of knowing, of course, that at that point in mid-1967 the medical build-up, so to speak, was not keeping pace with the troop build-up. It hadn't quite gotten there yet. So finally I got a letter saying something to the effect that "We'll make every effort to see that your surgical training is utilized." If I knew then what I know now I would never have bitten on it. If there ever was an open-ended statement, that was it. But, I said okay.

I went to Dr. Rhoads and said, "I have to do this." Of course, I didn't know about his Quaker background, at that point. He said, "Jim, let me tell you that the tradition at the University of Pennsylvania . . ." Parenthetically, I should tell you that during World War II the entire surgical staff of the University of Pennsylvania was the 20th General Hospital in the China-Burma-India Theater.

When I was a freshman second year resident, he was my professor. Dr. Rhoads said, "The tradition here is, if a man goes to war, his place is preserved. So when you're ready, you'll be welcomed back."

I never even imagined that. And then he wrote on piece of paper which he gave to me. It was his home address and phone number. I was already married to my first wife and had a couple of kids. He said, "You go home and give this to your wife and you tell her that while you're gone, if she has any needs, she's to call me."

So off I went, first to Camp Lejeune. That was an amazing experience for me because I literally went from home to the Marine Corps. There was absolutely nothing to suggest the existence or presence of the United States Navy. I was in Lejeune in fatigues and combat boots, running the obstacle course, and sitting through their classes--the usual stuff that you do for 6 weeks with the Marines. It was bearable. Obviously, we didn't do what the typical Marine grunt would do but, nevertheless, they made it pretty serious and scary in the sense that this is what you're going to do.

One anecdote I remember from there was one of the many speakers that we had. This Marine, who was a noncommissioned officer, was talking about being in combat. He said that one thing we'd never have to worry about was being protected by the Marines. "Doc, if anything happens to you, it means that every Marine around you is dead." I remember thinking, "What kind of consolation is that?"

Anyway, I finished there and I still remember coming back to Philly to get ready to go. My orders were to go from Travis [AFB] to Okinawa to Vietnam. My dad came down to Philly from Pittsburgh to see me off. He took me out to the Philadelphia International Airport. My dad was a regular lower, middle class guy. He pumped gas, sold storm doors. He never got beyond that level in his lifetime but he thought like a big shot. He always did. Together we went to the airport. I had a TWA coach ticket to San Francisco. When we arrived there, he went up to the TWA counter and said, "I'd like to speak to the manager." I was off to the side as this guy comes out, and my dad said to him, "This is my son, Dr. Finnegan. He's a surgeon from the University of Pennsylvania and he's leaving for Vietnam to operate on the Marines. I want him to fly first class." I wish I had that much chutzpa. My dad did it all the time. Needless to say, that's how I went, first class.

I went through Okinawa and landed in Danang. I got there late in the evening. It was just dusk. The building at the Danang airport was basically a big tin hut. I was standing on

Vietnamese soil and had no clue what I was supposed to do or where I was supposed to go. I was assigned to Headquarters 3rd Medical Battalion, 3rd Division.

**When is this?**

September of '67. I went up to a counter. I think there was an Air Force airman there and I said, "I just got here and my orders are . . ."

"Oh, you have to go to Phu Bai. And there's nothing going out to Phu Bai until tomorrow morning."

I was very naive so I said, "What am I supposed to do until then?"

He said, "Doc, if I were you, I'd find myself a patch of ground out there and get some sleep."

There was a dirt road, no lights, and a big cyclone fence. And by now, it was dark. So I went out looking around and found a patch of grass. I put my satchel down, stretched out on the grass, put my head on it, and fell asleep.

At pre-dawn, when there was just the barest streak of light coming over the horizon, a noise literally blew me awake. I was scared, and bolted up in the grass. It was still kind of dark. I had fallen asleep under the back end of an F-4! This guy had just started up the plane. I don't know where he was going but these engines came on behind that cyclone fence. I don't know how far it was from me, maybe 20 yards or so. I thought I was going to lose it all right then and there. That was my welcome--my "Good Morning Vietnam!"

Later in the day I got a ride up to Phu Bai, my first official stop. They gave me a bunk in what we used to call "Southeast Asian" huts--plywood with a tin roof. There was a triage area with a big mud yard in front of it. The airstrip was out there. I still remember the awkwardness. What I didn't realize was the battalion was in the process of moving north to Dong Ha, which became the headquarters of the 3rd Marine Division, and the 3rd Medical Battalion was moving there also. I think I arrived as that was beginning.

For the couple of weeks I was there, we received casualties sometimes by ambulance, a lot of times by fixed wing aircraft, rarely by helicopter at that time.

I got into the swing of things with triage, operating on a few people. When you first arrive, people would ask, "Who are you? Where did you train? What can you do?" They kind of size you up a little to see what's appropriate. Although I must say, wherever I went, one of the things I've always revered are my surgical credentials from the University of Pennsylvania. Everybody knows HUP [Hospital of the University of Pennsylvania]. So when you go into a strange place the first thing any surgeon says to another surgeon is, "Where did you train?" So I'd say HUP. Everybody knows that. It's like saying Mayo. So that got me a lot of entree.

Phu Bai was kind of a quiet blip in my experience. There were casualties but never big time. There wasn't much incoming. Sometimes you'd hear something off in the distance. Then we got word that we were all shipping up to Dong Ha. They had built that combat base, which was actually quite large. The headquarters of the 3rd Marine Division was about half a mile down the road from us.

**So you were assigned to Delta Med?**

Yes. We took casualties at a much more frequent rate because now we were servicing the whole 3rd Marine Division along that stretch of the DMZ. There was a lot of action at that point--patrols, clashes, battles, and everything else. Then the NVA began shelling Dong Ha. This was dramatically more than at Phu Bai.

There was a huge triage area, maybe 2,000 feet, where you could put a whole row of litters. We could take a dozen litter casualties at the same time. Remember with [Dr. John] Parrish's book, *12, 20, and 5: A Doctor's Year in Vietnam*, when the chopper pilots called in, that was the code. That meant walking wounded, litter wounded, and dead. That's what the numbers were. When you heard the numbers, you knew what to expect in terms of getting everything set up.

We could take a pretty large load of casualties at one time and we did so with some frequency. But we were also within range of the NVA gunners just on the other side of the DMZ and they used to shell the medical area. There were bunkers out in the front of Triage. A big steel revetment about 10 feet high and maybe 40 or 50 feet long had been built. As I recall, it wasn't exactly facing north. Nevertheless, when we'd take incoming, we'd all run out and jump in these bunkers. There was always a lot of swearing. Why the hell are they firing at the hospital?

Well, one of the things someone discovered is that we had a big, white flag with a red cross sticking up on top of the hospital. Somebody pointed out that artillery observers absolutely love that. It gives them a perfect target to sight on and measure their distances. We took the flag down.

I was there from October thru January. It was just that kind of a steady thing. Those of us surgeons would alternate call. You would go Triage, first call, second call, third call. One surgeon was designated triage surgeon. That meant whenever the call came . . . Actually, you didn't need much of a call because you could hear the sound of the helicopters coming in from miles out.

**Hueys?**

It could be anything--Hueys, and the larger helicopters. The Jolly Green Giants also. It was almost all helicopters, at that point. Over that 4-month period there was a steady flow of casualties. If there was a battle going on or a recon patrol got into trouble, that would generate a large number of casualties.

And there was a pretty regular amount of incoming. I recall one incident when there was an internist with us named Terry Andrews from San Francisco. He did the sick call bit and all that and wasn't involved in the surgical end of it. We always had four-holer latrines up there. One day in October or November, I can't recall which month . . . Anyway, everybody remembers it because the Seabees came and put in a regular porcelain toilet. This was something. Everybody was looking at it . . . If the line wasn't too long you could actually sit on a toilet and enjoy yourself instead of sitting on the plywood.

Well, Terry was sitting there one day when we started getting some very heavy incoming. As Terry tells the story, he was sitting there thinking "Shall I finish this or should I get the hell out of here?" Serendipitiously, right across the catwalk from the toilet was a little bunker. I don't know whether God thought of that or someone actually thought of it. He said, "I jumped up off the shitter, dove into the bunker, and the toilet took a direct hit with a 122 artillery shell." It was one of the tragic comedy things. You wouldn't have found pieces of anyone who had been within 10 feet of that thing. And our toilet was absolutely blown to smithereens. There were little pieces of porcelain all over the place. Terry told that story for years. And, I have to say, it was the most photographed commode in the history of the war because everyone knew we had had this beautiful toilet. We used to have guys from other units come and use it. It was a prize possession.

When I got to Dong Ha, there were only a handful of surgeons for the whole 3rd Marine Division. We didn't have that many people. After operating a little bit they kind of checked me out and I was pretty much on my own after that.

**Obviously, you hadn't seen anything like this in medical school.**

No. On the other hand, I actually wrote an article which I published in a journal called SG and O, which doesn't exist anymore, *Surgery, Gynecology and Obstetrics*. When I came back I wrote an article called "Triage at Khe Sanh" and it got published. The gist was: Although these are things that most of us have never seen before and may never see again, for the most part, the application of basic surgical principles is still your first line of care. It's not as though we invented anything brand new, or that we had never heard of it before. Stop the bleeding, get rid of the bad parts, put the other stuff back together. It's basic surgical principles but applied a little more rapidly than you would at 34th and Spruce in Philadelphia. But, nevertheless, it was basic surgery. I think the one big difference for me is . . . You have trauma in Philly; you have trauma in Washington. What's the big difference?

There are two things. A lot of surgeons who only have civilian experience don't have a working knowledge of ballistics--muzzle velocity, missile size, and kinetic damage to tissue. I used to give a lecture on it. If you take the human hand holding a knife stabbing someone, that hand is moving on an average of 8 feet per second as it approaches the body. That's very slow. What that means is that the only injury will be the track of the knife blade. There's no kinetic energy associated with that. Now if that happens to be tracking into your left ventricle, you're going to die. But if the blade just goes through the ribs into the lung, you're going to have a hole in your chest and a lung injury, but you're going to be fine because nothing else happens except that track.

If you take a police .38 special revolver that's clean and well cared for, the muzzle velocity is 938 feet per second. That imparts a reasonable amount of kinetic energy which means the amount of destructive force that passes through tissue as the missile goes through the body. So that bullet, for example, as it goes through your belly, is not just going to make a hole, but everything a couple of inches around it is going to be damaged severely by the kinetic energy of that missile and the energy it imparts.

If you move to the M16 or the AK-47, you're talking about a muzzle velocity of 3,250 feet per second. It's nothing more than a variation of $E=MC^2$, only E is KE--kinetic energy. Translation: destructive force to tissue = mass or bullet x velocity squared--3,250 feet per second squared to make up that kinetic energy. For example, if an AK-47 round goes through your chest and just slides beside your heart without hitting it, it will blow off the side of your heart, even though it didn't hit the heart.

So the first thing you see in combat casualties that you're not accustomed to seeing in the civilian world is the amount of tissue damage from these missiles because of the tremendous velocity they carry.

The second thing is the helicopter. Because it was a helicopter war, almost the instant a casualty occurred--CHOPPER! I still think that the great unsung heroes of the war are the chopper pilots. I don't know why they all don't have the Medal of Honor. Every time casualties go down under any circumstances, the first thing they do is call for a chopper. And how many times did these guys have to fly into hot fire zones. They had to slow down to land becoming total targets. They'd go in under fire and pick up casualties. I have to imagine that the amount of injury and destruction to them was considerable. My point is that when they succeeded, they

delivered to us 18-, 19-, 20-year-old Marines, the healthiest people on the planet earth, with massive injuries that, under any other circumstances, would kill anybody else, or, certainly, within a short period of time, would kill anybody.

By chopper, they would arrive at Delta Med in Dong Ha in 7 minutes! They were barely alive, but still alive. The new experience was actually seeing these people sooner, who under other circumstances, would just be dead as in World War I, when they would wait for an ambulance to be driven 20 miles to the rear, or during World War II, which was pretty much the same thing. In Korea, helicopters were used. I don't know the percentage of casualties they actually evacuated, but it was pretty small. M*A*S*H would make you think they all came that way but that's not true. They had these tiny helicopters that could just take a couple of people.

It really wasn't until Vietnam that we had the experience of having huge fleets of helicopters on the ready in the fire zones taking out massively wounded kids, plopping them on our triage tables alive or barely alive, sometimes within minutes.

We had a resuscitation system that was honed to the point where I don't think any civilian organization, at least at that time, could begin to match. It was basic, but extremely effective. For example, sometimes we had a kid come in all shot up with no vital signs or blood pressure and almost bled out. The first job was to resuscitate him.

If I were the triage surgeon and we got in a big batch of casualties, the first thing we'd do is sort them, so to speak. We had 12 litters and we'd want the worst casualty in litter number 1, the second worst on 2, etc. Let's say the 12th was a guy who maybe had been shot in the belly but his vital signs were stable and he was fine. He was going to have to be explored but was stable and could wait. This other guy who had no vital signs, was bleeding like a stuck pig, and we either resuscitated him or he'd die.

We could do all this in a second. It got to the point where you could look at the casualties and put him there and him down there. That's how fast it went. The first team went to the first litter. This is where the criticality was at its height. We had the chaplain, the orthopedic surgeon, the corpsmen cutting off every stitch of clothing. In seconds, the patient was completely naked. In a few seconds more, both groins were opened with a scalpel and both saphenous veins were cannulated with IV tubing. Forget needles. We put the tubing right into the veins. Two pumps--boom!

Within minutes of that kid coming through that door, we were literally pumping stuff into him to restore his blood volume. We never cross-matched a unit of blood the whole time I was there. We used type-specific blood. Today, that would horrify people. A trial lawyer would have a field day if you ever even mentioned that today. We never cross-matched anybody because we knew what the blood type was based on his dogtag. If he were type A: "Bring me 20 units of Type A." In a matter of minutes, this kid was getting blood and fluids through two huge bore IV cannulas. He had already been intubated instantly by one of our anesthesia people. No heartbeat; the chest was opened very quickly. So the resuscitative effort was slick, quick, skilled, and effective. I've been asked, "Did anybody ever fall between the cracks?" I can honestly say no. There was never a time I knew of somebody who died because we couldn't get to them, at least once they got to us. You would think that with volume casualties, that wasn't possible. But I never saw that happen. We took care of everybody.

You might be interested in this sidelight. When I got to Delta Med at Dong Ha, there was a surgeon from Boston. He was the senior surgeon at Delta Med. When I first got there, the casualties were lying on canvas litters supported by saw horses and if they were bled out or they couldn't find a pulse, they were beating on their chests--external compression.

I remember going to this surgeon and saying "That's totally ineffective in a patient who's bled out." At that point, the heart is very small because there's no blood in it. You can compress it all you want and you're not doing anything. You have to open the chest to manually squeeze the heart until you get the patient's volume back up.

In the early '50s a Dr. Jude from the U.S. and Dr. Kiewenhoven from Belgium invented closed chest cardiac massage and it became all the rage. Everything went from having to open the chest to this. Well that's great for heart attacks and anything that stops the heart. But if there's no blood volume . . .

This guy wouldn't pay any attention to me. And I was so angry. You can't resuscitate kids this way. I wrote to Dr. James Jude, who was then at the Miami Heart Institute in the fall of '67. I said, "Dr. Jude, you don't know me. I'm a surgeon with the Marines in Vietnam. I've been watching some of my colleagues attempt to resuscitate patients in hemorraghic shock with closed chest cardiac massage. I'm trying to tell them that this is a case for open chest massage and I'm getting nowhere. Would you be kind enough to help me?" He wrote back and said, "You're goddamn right!" So we switched. I made a kit with a scalpel and a chest retractor in it; that's all. Make an incision at the fifth interspace anteriorly, put the crank in, spread the ribs, put your hand in, and squeeze the heart. Two minutes or less. We had one kit at the first three or four stations where we might be likely to do that. As soon as we found a pulseless Marine--multiple injuries, bled out, we'd do this.

So, for those 4 months my experience was operating on casualties and ducking the incoming. We never heard of Khe Sanh at that point. I didn't know what or where it was. Around the end of the year was when it started to heat up. That's then we started to hear that something was happening at Khe Sanh.

CDR Bob Brown was commander of Delta Med. I think he was a career Navy man at that point. He had sent some guys up there--a surgeon and an anesthesiologist, and one or two other people. He came to me in mid-January and said, "Jim, I have to ask you a favor. Would you go to Khe Sanh?"

I said, "Sure, but I thought you had . . ."

He said, "I have a problem. I have to pull them out of there. Would you be willing to go and head the surgical team?"

"Sure, whatever you want me to do, Bob."

He then he got his fellow, Joe Wolfe, who was a general medical officer. Joe, in his internship, had 6 weeks of anesthesia or something like that. Joe was going to be sent up as the anesthesiologist. That's when my antenna went up. There's an anesthesiologist up there and he's sending up this guy whose had 6 weeks of anesthesia? Okay.

So I got on a Huey gun ship with my little ditty bag. Joe didn't go with me then. He came up later. All I remember is that when I jumped off the helicopter in this red clay plateau, I thought, "What is this? What are we doing here? As I jumped off, two other guys jumped on. I hardly saw them as the helicopter took off.

To make a long story short, the surgeon who went up there before me became somewhat upset when the first incoming started. He went into his bunker and refused to come out. The details are not verifiable at this point but I've learned since from others that that was the case. The problem Bob Brown had was that he had a surgeon and an anesthesiologist at Khe Sanh who said, "We're staying in the bunker." So I was there and they were gone.

There I was the new CO of Charlie Med. I don't where the designation Charlie Med came from. Eddie [Feldman] had been with one of the hill companies--I think 1/26. Don

McGilligan was out there with one of the other Marine companies. They pulled them in to me. So I had Ed, Don, and Joe Wolfe plus 26 corpsmen.

When I got up there, Charlie Med was a little compound right on the side of the airstrip because for evacuation purposes, we had to be right on an airstrip. Everything was all canvas tents with sandbags. The tents had holes in them and were flopping all over the place. It was madness!

Not too long after I arrived, incoming artillery ratcheted up to 2,000 rounds a day. Of course, it wasn't only directed onto Charlie Med but all over the base. Nevertheless, the base was a half a mile by a mile in size. But, of course, Charlie Med got more than its share of it.

Within a very short time, we had nothing above ground that hadn't been blown away. The corpsmen and I had little bunkers that were dug down maybe 3 feet in the ground with sandbags and wood on top of them. At the triage area, we just had sandbags and wood.

Every morning I was supposed to go down to a regimental briefing. There were a lot of mornings when you ran from truck to truck or pole to pole because of the incoming, even as you tried to walk down the path. That was another out of body experience for me. I would sit there and listen to these guys. Col. [David] Lownds was the CO of the Marines at Khe Sanh. The rest of the officers were there. Every morning they would go through the intelligence reports. One guy would say, "Outside Z2 R1 Perimeter we heard these clanking noises which we think were tank treads."

Tank treads! I'm thinking, "Jesus, they've got tanks."

Then there would be another report on the incoming. Another report would come in on a patrol that went here or there. There were sightings of this many enemy or whatever. Then, every once in a while, Lownds would refer to the "impending invasion of Khe Sanh," what forces the NVA had and how they were going to come in.

I pointed out that we needed some kind of protection at Charlie Med because we were getting shelled while we're caring for the casualties. I didn't see that I was getting anywhere with that argument. Finally, I had a discussion with the executive officer. "Some of these kids are getting re-wounded. It's not a good thing. It's bad enough they get wounded the first time."

And, to this day, I still don't know who said what to whom, but, sometime after that, a group of Seabees came over with something like a backhoe. They dug a good size hole in the ground maybe 12 x 20 x 10 feet deep, which they buttressed with what I think were 12 x 12s. They then put metal Marston matting on the top with layers of sandbags on top of that. They also built a little ramp going down into it.

Well, now we finally had a place where we could take the casualties! It was a pain in the ass to have to take them down the steps into the thing, but at least we were in there with some notion of being able to stand up and take care of them without worrying about getting hit.

Lounds now felt that the NVA's attempt to overrun Khe Sanh was imminent. I remember seeing a picture of the base very clearly. They had these curved arrows showing five routes onto the base. The primary route where they were most likely to come in is over here. The other possibility is over here, and the third one is up the draw through Charlie Med. Well, that got my attention. The perimeter was a hundred yards and you could see the NVA running around out there right across the strip. You could see them through binoculars. And right behind us was a half track with a .50 caliber machine gun on it and a couple of Marines. That was it.

I waited until the briefing was over because I never felt I had enough military moxie to even ask a question. These were all the Marine combat professionals. So I got this executive officer afterwards. I said, "Listen. I don't exactly know what I'm supposed to do here. I've got

four docs who wear .45s and are in danger of shooting themselves in the foot at any given moment. There are 26 corpsmen who don't carry weapons because they're working on casualties, and a little half track out there. You're drawing an arrow saying that there's at least a reasonable possibility when they overrun this place, which you're absolutely certain they're gonna do at any moment now, that they might come right up the draw through Charlie Med. I'm not John Wayne. I cannot be taking care of a casualty and shooting the enemy while I'm doing it. This is not the movies. Seriously, can you put some Marines out there?"

He said, "Don't worry, Doc. If they come up through there, the reaction force will come right away."

"Well, how long is it gonna take for them to get there if we're triaging casualties?"

He said, "Doc, it probably will take them a little while for them to be activated and ordered over there."

I said, "What do you want me to go back and tell my guys? What am I supposed to do?"

He said, "I understand that when the casualties come in, you strip them and take their weapons. He said, "Don't you take all the weapons from the casualties?" (In all triage, sitting behind you is what we called the ammo box. It was just a wooden box with a lid on it. We'd set the casualties' M16s against the wall. If they had bandoliers or grenades, we'd just throw them in the box. When I think about it now, if you handed me a grenade, I'd run screaming out in the hall.)

I said, "Of course."

"My suggestion," he said, "is to go back and make sure that your docs and corpsmen all have sidearms, M16s, and grenades and that you also dig fighting holes."

That's what he told me. So I walked back up to Charlie Med and I thought, "Now, there's just no way that I can say to all these guys, 'Okay. We're all gonna strap on our .45s and carry an M16, put some grenades in your lapels like John Wayne, dig your fox hole, and we'll keep taking care of the casualties. If they come up the draw, we'll become a Marine platoon.'"

The whole thing seemed like madness, absolute madness. So I just decided that I was not going to say that to the guys. We all knew the Marines were very concerned that the enemy was going to overrun the base. There was a sense that at any given time they could try to take the base. Everyone was aware of the fact that the siege went on. That's what it was all about.

As an aside, may I remind you that the incoming got so bad that all fixed wing aircraft were banned from Khe Sanh. Then it got to the point where even getting a helicopter in and out was very dangerous. They would land and then take off in a flash! They didn't sit on that strip but for a few seconds because the minute they landed, it was unbelievable. And, of course, Charlie Med always got the secondary effect of that added incoming because the helicopters parked right in front of us.

With the incoming so bad, they started air dropping supplies. It was one of those tragic comedy things because we would watch the planes come over, mostly C-130s with the rear hydraulic doors down so they could drop the load off the back. We would watch the stuff coming down. Let's say that a significant percentage of it didn't land in Khe Sanh. As a result, there were parachutes all over hell's half acre. Sometimes we had to send out a combat patrol to rescue the supplies.

Right outside of Charlie Med was a huge collection of used parachutes, open and sprawled all over the place. Everybody knew the plan was for "Charley" to come over the wire and get us. The Marines were actually begging for it. In all fairness, at least the senior veteran Marines wanted them to come. This is what Marines are born for. In that context, rather than

say to the men, "Get your M16 and dig a fighting hole, I said, "Guys, I've got a plan. We got lots of casualties to take care of and we can't be worried too much. We've got the Marines down there. If we see the enemy break through and come up that draw, what I suggest is that everybody get out and get under the parachutes. The enemy will never know we're there. They will roll right on by, and then we can go back and get our guns." At least I got a laugh from the guys. That was my famous parachute speech to the troops.

It's hard to say when you think back and try to space the time but the incoming seemed unrelenting.

**Was it coming in night and day?**

I will say that it was less at night. I don't know whether anyone's every documented it anywhere. I've always had this impression that the North Vietnamese did not like to fight at night. Maybe nobody does; I don't know. But no matter where I was--even at Delta Med--it was less at night. If we went to our underground bunker at night you could sometimes be in there with not too much happening.

But the daytime was different. Even the catwalk--the wooden thing that you walked up from the bunkers was a risk. There was a sniper across the way and you could never just get up and walk on it. You'd jump on and off of it because no one wanted to get picked off by that sniper. But as soon as there were casualties, we'd all charge from the bunkers up to the triage, which was in front right near the airstrip.

One of the hardest things was first off-loading the casualties. The chopper would drop in and the minute it did, the incoming would pick up. We called them mortar magnets. You'd run out, get the casualties off the chopper as fast as you could, and they would just lift off and go as fast as they could. Then you had to bring the litter about 20 yards from the landing pad into triage.

It was the same thing if you were evacuating casualties. Once we got everybody stabilized and things were quiet, we'd call for choppers to get them over to Dong Ha or wherever they were going. And, of course, as soon as the chopper came in, the incoming would start. We had to set up a wall of sandbags from the door of the triage bunker to the helicopter pad so we could run low behind the sandbags and try to get to the chopper without getting hit.

**What's the Jonathan Spicer story all about?**

The Jonathan Spicer story has been written up in many places. This is not my story in the sense that it was in the *Los Angeles Times* and many other places. There are multiple articles about Jonathan Spicer. It's one of the many stories that came out of Khe Sanh.

Jonathan was the son of a preacher from somewhere down South. I think he was drafted into the Marine Corps. According to the story, he immediately informed his superiors that he was a conscientious objector. He would do anything they wanted but he wasn't going to fire a gun. Somehow he was passed through basic and ended up in Vietnam. Once he got there, he was assigned to a Marine hill unit. He kept saying to his superiors, "I'll do whatever you want me to do but I will not fire a gun." The story, as I heard it, was that his CO was so disgusted with Spicer that he was going to discipline him in some way. Someone said, "Let me take him and maybe he can do something else." And so they brought him to me at Charlie Med.

**So, he wasn't a corpsman.**

No. He was a grunt Marine. The kid was not a coward. He just didn't want to be a shooter. So he became our main litter-bearer. He would run back and forth to the choppers under fire. This kid was fearless. We loved him. I still remember the day we were standing down in the bunker--Don McGilligan, Eddie [Feldman] and I. Suddenly somebody yelled, "Spicer's down!" He was moving litters and took shrapnel right through the center of his chest.

They brought him quickly into Triage, right onto the first litter. He was gone. No pulse. No blood pressure. Don McGilligan was standing beside me and said, "I think it's pericardial tamponade, meaning blood in the heart sac compressing the heart. If a fragment penetrates the heart, first it has to go through the heart sac--the pericardium--then into the heart. If the heart sac hole is small enough, the blood will spurt out of the heart and build up in the sac and compress the heart.

I said, "Don, I think you're right," and we got that kit I told you about, opened his chest, massaged his heart, put a single stitch in the hole in his heart, and he came back. Everything seemed dandy. He had been intubated with an endotracheal tube and we got him stabilized.

We then called Delta Med and told them that Spicer had an open chest wound, a sutured hole in his heart, and that we had to get him out of Khe Sanh and back to Delta Med big time. We couldn't keep anybody at Khe Sanh. Once we stabilized them, we had to get them the hell out because we didn't have the facility to do anything else.

They medevaced Spicer and for a long time nobody could find out what happened to him. I heard all kinds of stories that he was dead, and this, that, and the other thing. We finally got information but I forget who wrote the letter. To make a long story short, he was medevaced first to Danang and then to Japan. According to the story, which I think has been verified by a number of sources, he died in Japan "of infection." It's hard to know exactly what that means. But because of his heroism, he got the Navy Cross.

There was a tremendous amount of newsprint at that time about Jonathan Spicer and we were very excited because we thought we had saved our boy and everything was going to be all right. Years later I saw his name on the Wall. It was the first time I knew that he was actually dead. And it wasn't until just the past year or two that I learned that he had died in Japan. But he was a great, great kid and absolutely a hero. We all remember Jonathan very well.

**Do you remember any other cases that might have been unusual?**

Yes. I've written a couple of things that are unusual. I don't know whether I'd really be able to publish them. I'd mentioned going to the seminars at LaSalle University. A year or two ago after I gave my little talk and we were sitting around in seminar fashion, one of the girls raised her hand and said, "Do you ever have nightmares? It's always the girls who ask the good questions. And I said, "Honestly, I don't."

I don't have nightmares in the sense that I lay awake at night thinking these horrible thoughts about something that happened in Vietnam; I don't. I do have recollections of things that recur frequently that I don't think I'll ever stop thinking about. But I'm mentally healthy enough and secure enough in who I am that I recognize them for what they are, memories that I'll just never get rid of."

One of these memories is from Dong Ha and not Khe Sanh. You remember the 20, 10, and 5? When the helicopter landed, the dead were removed and taken to Graves Registration. We never saw them. We took the litters and walking wounded. An order came down from somewhere that all the KIAs would have to be pronounced dead by a physician. Of course, everybody had the same kind of reaction. "What kind of nonsense is that?"

We had this little rotation set up where we had to go over to Graves, look at the bodies and say, "Yes. He's dead." There would be all kinds of horribly damaged corpses. It was awful. All I could ever think of was, "I wonder how those kids could work in Graves Registration?" For the Marines it was voluntary duty.

One time I went over to Graves and looked down at this one kid lying on the floor. I'll never forget it as long as I live. His body from the neck down was intact. He was in jungle fatigues and boots. I can only guess at this. It must have been an extremely high velocity missile such as a large piece of artillery. It must have gone across the back of his head, just behind his ears and literally taken off the whole back of his head. In so doing, it somehow sucked his brains and his skull out of his skin. What was lying on the floor from the neck up was a big pancake of skin flat on the floor with eye sockets and a flat nose, mouth, and ears. There was nothing but this round, flat, moon face lying on the floor with nothing behind it. That image has always stuck with me. I will always remember that moon face lying on the floor.

That identification procedure only went for a short time and then it was rescinded.

I wrote a piece a few years ago which I entitled "The Scream." This happened in Phu Bai and was one of my earlier experiences.

One night we took in a bunch of casualties. There was this big, heavy-set Marine. Right about at the groin level, his right leg was completely severed but still on the litter. And he was bleeding like mad. I remember finally finding the femoral artery and clamping it. We were resuscitating him and finally got his pressure back. I said, "We've got to get this kid to the OR." But his leg was literally not connected to his body anywhere. It was totally severed all the way around. So I said, "Let's get rid of the leg before we take him back to the OR."

But when we tried to move the leg, we could see that the only thing that connected it to his body was the sciatic nerve. I don't know if you've ever seen a sciatic nerve but it's quite a thick band of tissue. So here was this big nerve coming out of his butt, so to speak, and going into his leg.

I took a scalpel and cut the nerve to get the leg out of the way. Just as I did that, he let out this blood-curdling scream. He was not really conscious at the time. If he had been awake, I never would have done that. I can rationalize and say, "You had to do it; you had to get the leg out of the way, whatever." But I just remember thinking, "What have you done?" That's one of the things that hangs with you.

**Well, it's been over 35 years since all of that happened. Do you think about Vietnam much anymore?**

Yes, I do. But aside from these somewhat dramatic stories I've told you, I have to tell you that there's hardly a week that goes by that there isn't some reminder that I did what I did. But in the same breath, I will also tell you that most of those reminders are extremely positive. What I mean by that is this. There was a time when every textbook of surgery started with a chapter on military history. I remember my first textbook of surgery was *Christopher's Textbook of Surgery*, and the first chapter was military history. In one of those book, and I'm not sure which one, the opening chapter had a quote at the top. It said, "The only victor in war is the surgeon."

I will tell you, based on my experience in the last 35 years of medicine, that that statement is absolutely and unequivocally true. It's true despite the social protests of the late '60s and so forth and the unpopularity of the war. It's true despite the many stories that you and I have heard about guys who came back and were spit on and treated badly and so forth. I'm not

saying that I didn't have some disconcerting incidents but, for the most part, I came back with a great new professional credential. I was a Vietnam combat surgeon. I had done thousands of cases. That was such a distinguishing mark when I returned to the University of Pennsylvania to complete my residency. I had done so much more surgery than anybody in the residency that I had kind of an aura about me. In addition to "HUP surgeon," I now carried the label Vietnam Combat Surgeon for the rest of my professional life. To this day, I can walk into a room and someone will say, "Jim was a surgeon in Vietnam."

So for me, it was a remarkable positive. I got credit for a year toward my surgical training. I carried that experience with me into every theater I went into. When I finished my training, Dr. Rhoads wanted me to be an academic professor of surgery. He sent me to one of the other medical schools in Philadelphia to join the surgical faculty. Within minutes, it was, "Oh you were a surgeon in Vietnam." But everywhere I went since then, it has always been on the table or remarked upon as one of my credentials.

By and large, it was the totality of the experience for me as a surgeon. I did surgery that I'll never get to do again and for what it contributed to me as a surgeon, it was a watershed moment in my life in a very positive way.

The only pause I ever had came from one of my own professors. When I came back, I went to the Philadelphia Naval Hospital. At that time we were told not to wear our uniforms when we were off base.

I was at Penn, which was not one of the hotbeds of the protest movement in '69 and '70. The kid who was the president of the pre-med honor society, AOA, called me. He asked if I would be willing to speak to the pre medical honor society about my experiences in Vietnam. I said, "Certainly."

I don't know if you're familiar with Penn or not, but there's a place called Houston Hall, which is an old part of the University. He said the event would be in Houston Hall on Friday night. The night before the speech, this kid called me at home and said, "Dr. Finnegan. I'm just calling to give you the option of canceling the talk because I've been told to inform you that we cannot guarantee your personal safety."

I forget his name but I said, "I'll guarantee my personal safety. I'll see you at 7:30." So I showed up at Houston Hall but I did have second thoughts. I walked into the room which was filled with these hippy looking characters. There were some legitimate types, pre-med guys, but plenty of these strange looking hippies. I thought, "Oh, what have I got myself into?"

I did my usual disclaimer. "I went to Vietnam as a surgeon to take care of the casualties and I'm here to talk to you about that. I'm going to warn you in advance that I will show you slides of some of the injuries. For those of you who are squeamish or concerned, I think now would be a good time for you to wait outside. I want you to be forewarned that some of this is not pretty."

So I went through my presentation. When I was finished, you could have heard a pin drop in the room. By then, I was girding my loins figuring that this is about the time one of these nuts was going to jump and throw a tomahawk at me. To my surprise, I had a series of extremely polite and professional questions. It went for another hour of questions and answers. Some people came up afterward and talked to me, including some of these strange looking characters. But no one ever said, "Boo."

On another occasion, I had to come from the Naval Hospital to Surgery at Penn to do some paperwork about coming back into the residency. I had my uniform on. By this time, it was June or July of '69. I was going to get out in September and by that time all my medals had

been presented. So I had three rows of ribbons on my whites. I figured, I'd park, go into the Department of Surgery, do my business, and get back to my car.

I got on the Ravdin elevators. It was pretty crowded, maybe eight or nine people in the elevator. Right across from me was Dr. Jack Mackie. He was Dr. Rhoads' right hand man and a senior surgeon. I knew him from before, knew that he had never been in the service. He looked at me and said, "Jim, did you buy them medals or earn 'em?"

I said, "Dr. Mackie. My guess is that it was a little bit of each." And then I got off the elevator. But I never forgot it. I felt like saying, "I bled for these goddamn things." In retrospect, it's always easy to come up with these wonderful quips. But I never forgave him for it. That was such a low blow. It wasn't like he didn't know where I was and what I had been doing.

**They talk about the surgical advances that are made in wartime. Did you see any of that in combat surgery?**

I think so. I'm hesitant to try to catagorize it and say, "Yes, these three things happened." But I think that if you look at the history of surgery, it's become axiomatic that many of the advances in surgery occurred during or immediately after a war. It's the history of surgery. In World War I, the mortality rates for certain wounds approached 100 percent. For example, if you had a chest wound, the mortality rates were enormous. During World War II they learned how to drain and take care of those types of wounds and that mortality rate decreased dramatically.

The whole concept of treating people in the field has been greatly advanced by. In actual fact there is little that you can do out there. Probably the single greatest thing that can be done, if it can be done, is applying pressure on a major bleeding point, which can be life-saving. But the other stuff which was once thought to be field procedures--tracheostomy, even starting IVS--has long since been given up. That has translated into major protocols in trauma systems in the States. For example, there was a time when paramedics were trained to do many things out in the field.

Today, as a result of our experiences in Vietnam, a lot of trauma centers with their ambulances and paramedic squads, have learned what's called "scoop and run." I'm simplifying a complex discussion but my point is, one of the things we've learned in war is that if someone is injured, what you want to do is get them to a place where you have people who can fix the injury. All this temporizing stuff out in the foxhole or on the street . . . I can't tell you how many times in Vietnam kids came in with needles stuck in the subcutaneous tissue with nothing resembling an IV in a vein. I'm not criticizing the corpsmen but if you're out in the woods in the dark, you can't start an IV. It's just wasting time.

The helicopter thing brought up the whole concept of rapid transport. Get him to a place where people can take care him. Don't dilly dally around doing all kinds of fancy stuff.

There's also the treatment of vascular injuries. There was a Col. Norman Rich who compiled a vascular registry in Vietnam, and then on the basis of that, wrote innumerable articles. So the whole concept of treating traumatic vascular injuries made a quantum leap as a result of the work he did in Vietnam. The whole trauma industry made quantum leaps based on the type of care that was developed in Vietnam.

**What are you doing now? Are you still affiliated with Penn?**

Only as a medical school alumnus.

A major medical center outside Philadelphia then asked me to come there as the chairman of the department of surgery. They were just setting up heart surgery. I took that job. It was a huge department. I had 13 divisions of surgery and so forth. It was a real challenge.

I was 10 years in that position and then I resigned from that. I had been teaching for 30 years and I think I just needed to move away from it for awhile.

I then went purely into private practice and began a slow evolution with my son. "Dad, come help me with this. Come do a little bit of that." The next thing I knew, it evolved into a full partnership so now he and I . . . We've been together for almost 2 years now and we just formalized it recently. There's another university in New Jersey--Cooper University Hospital in Camden, which is part of the Robert Wood Johnson organization. They asked us to join their full time faculty. So as of August 30th, Matt and I are full time at yet another medical school. It's called Robert Wood Johnson School of Medicine. As an interesting sidelight for me, Cooper University wants to build its own medical school. There's never been one in South Jersey. So I'm part of the president's commission to find the wherewithal to build a new med school.

**What's your title?**

I've always been a professor of surgery. When I went to the Medical College of Pennsylvania the second time as head of cardiac surgery, I went there as associate professor and then became Professor of Surgery in 1983. I've been a professor of surgery since then. I still carry those titles. And now, at yet another medical school, my guess is that some time within the next few months, I will be Clinical Professor of Surgery at the Robert Wood Johnson School of Medicine. I hope that's the end.